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The ambiguities of coercion: Mapping adolescents' experiences of coercion in institutional everyday life

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Abstract

The article presents a metasynthesis of qualitative studies, which have described and analysed adolescents' experiences of coercion in institutional contexts such as psychiatric care, child welfare and juvenile justice. The study finds that coercion is an ambiguous practice, mainly used for protection and treatment purposes, while it is often experienced as punitive. Acknowledging the ambiguities of coercion can contribute to a more nuanced understanding of practice and experience, which is useful for reducing the harmful effects of coercion and strengthening participatory methods of care and treatment.

KEYWORDS
adolescence, children in care, rights, behaviour problems, mental health

INTRODUCTION

Children in state care experience coercion in multiple forms as a part of their everyday life (Nowak, 2019). The form and frequency of coercive measures differ between jurisdictions and types of institutions; however, most children living in state care experience some form of coercion such as the use of physical force, restraints, forced medicalisation, seclusion or restrictions on mobility, contact or communication (De Valk et al., 2016; Furre et al., 2016; Nowak, 2019; Nyttingnes, 2018; Roy et al., 2021). This article presents a metasynthesis of qualitative studies,

which explore adolescents' institutional everyday life focussing on their diverse and ambiguous experiences of coercion. The article draws on experiences of coercion across child welfare, psychiatric care and juvenile justice, and thus extends on previous studies looking across these sectors (Engström et al., 2020; McElvaney & Tatlow-Golden, 2016; Schliehe, 2014; Slaatto et al., 2021). Children in state care often oscillate between these sectors during their time in care, which makes all three sectors relevant for understanding the experience of coercion over time. Drawing on Foucault's concepts of power from 'Society must be defended' (1976) and 'Security, territory, population' (1982), we highlight the multilayered and ambivalent experiences of coercion in adolescents' everyday institutional lives.

Coercion is a contested practice that can be viewed as necessary for safeguarding children and adolescents while also implicating significant risk of harm. Harmful effects include inflicting pain, trauma, negative impact on well-being, health and even resulting in death (De Valk et al., 2016; Furre et al., 2016; Nielson et al., 2021; Nowak, 2019). The use of coercion is regulated by national legislation and international conventions such as the UN Convention of the Rights of the Child and The UN Convention against torture and inhumane treatment. While these conventions have served as guidelines for national legislation for nearly 30 years, it has recently been claimed that coercion remains an unresolved global crisis, and human rights violations have been repeatedly documented in institutions for children and adolescents in the last decades (Pariseau-Legault et al., 2019; Roy et al., 2021).

The use of coercion is not systematically documented, documentation is difficult to access and comparison between sectors and jurisdictions is challenged by different systems of registration (Souverein et al., 2022). In all sectors, coercion is used to protect adolescents from harming themselves or others. In juvenile justice, coercion is used for rehabilitation and punishment of legal transgressions, while in psychiatric care, coercion is used to enable treatment such as forced medicalisation or feeding. In child welfare, coercion is used particularly to regulate behaviour and sanction rule breaking, while seclusion, physical restraints, surveillance and room/body search are also frequently used (De Valk et al., 2016, Ulset & Tjelflaat 2012). In practice, the logics that legitimise coercion are often blurred between protection, treatment and punishment (Pelto-Piri et al., 2016; Henriksen & Prieur 2019). Coercion is found to have negative effects on treatment because it undermines trust in staff and results in opposition and resistance to rehabilitation (Furre et al., 2016; Pelto-Piri et al., 2016).

We apply a broad definition of coercion to include any practice that adolescents find restrictive in everyday institutional life. This includes a wide spectrum of practices such as physical restraints, seclusion, behavioural regulation, persuasion, interpersonal leverage and threats. These latter forms of coercion are often vaguely regulated by legislation, and they are undocumented and remain poorly understood from an inpatient perspective (Coutant, 2016; Nyttingnes, 2018; Paradis-Gagné et al., 2021). This article highlights the ambiguities of coercion as they are experienced by adolescents. As argued by Hottinen et al. (2012) 'one of the key developmental tasks of adolescent development is the establishment of independence and autonomy which makes containment measures an important area to study in this particular age range'. This article provides insights into adolescents' experiences of coercion, which is vital for the development of policy, legislation and institutional practices providing protection and care for the most vulnerable adolescents in the care/treatment system.

COERCION AS A CONTINUUM OF HARD AND SOFT POWER

In this article, we conceptualise coercion as a continuum of hard and soft power. Hard power includes practices such as physical restraints, forced feeding/medicalisation and seclusion, while soft power includes practices such as behavioural regulation, motivation and living by institutional rules. Analytically, these practices are not viewed as distinct categories, but rather as interrelated practices in a coercion continuum. We draw on two different series of lectures by Foucault to understand the different forms of coercion that adolescents experience in institutional settings. The first series of lectures stem from Foucault's lectures, published in 'Society must be defended' in 1976, where he investigates institutional forms of power introducing the concepts of discipline and surveillance (Bentham's panopticon) as techniques, which centre on manipulating and controlling the body with individualizing effects (Foucault, 1976/2003). These techniques also rationalise and economise the cost of exercising power by means of surveillance, inspections, hierarchies, book keeping, reports, etc. as a disciplinary technology of power (Ibid. p. 242).

The second series of lectures: 'Security, territory, population' from 1978 (Foucault, 1978/2007), he concentrates on liberal forms of governing, emerging in the second half of the 18th century. In these lectures, he modifies the disciplinary technologies of power towards the shaping of individuals through regulation and guidance. This is not a disciplinary form of power, but rather a form of governance enacted by guidance, persuasion and motivation, which promotes self-regulating techniques conducting individuals in the direction of visions (Ibid. p. 197–198). In this liberal form of governance, the use of 'hard power' is viewed as problematic and undesired for the regulation of individuals. Rather, power can only be exercised over free subjects. Foucault writes, 'By this, we mean individual or collective subjects who are faced with a field of possibilities in which several kinds of conduct, several ways of reacting and modes of behaviour are available [...]Freedom may well appear as the condition for the exercise of power' (Foucault, 1982/2001; 342). While power and coercion are distinct concepts, we argue that coercion can be conceptualised as a continuum of hard and soft power. That is, hard power being a form of power, which adolescents cannot easily evade, while soft power is more subtle and regulatory for adolescents' conduct and self. This enables analysis of a wide range of coercive experiences ranging from physical restraints, confinement and forced medicalisation to practices integrated in the regulation of behaviour, emotions and everyday dispositions through rules, motivational talks and rehabilitation. This approach to studying coercion as a form of power extends on the work of Ben Crewe, who explored prisoner's experiences of soft power (assessment, treatment and self-governance) as key elements of the 'pains of imprisonment' (Crewe, 2011). We aimed at showing how soft and hard power operate in extension of each other as a multilayered experience, and in light of each other rather than as distinct practices; soft power is often exercised through the threat or potentiality of hard power and hard power is exercised with promises of soft power if behavioural or emotional control is regained. This provides nuanced insights into the ambiguities of coercion as practice and experience.

METHODS

The article is based on a metasynthesis of qualitative studies on adolescents' experiences of everyday life in institutional contexts.[i] Metasynthesis is a method, which aimed at systematically reviewing and integrating findings from different studies to provide a rich and nuanced understanding of a particular theme or topic (Kinn et al., 2013). This metasynthesis centres on

adolescents' experiences of coercion in everyday institutional life. Compared with a systematic literature review, which is broader in scope, the metasynthesis aims for in-depth analysis and synthesis of findings (Ibid). The scarcity of qualitative studies on adolescents experiences of coercive practices calls for an approach, which forefronts these experiences from adolescents' narratives of everyday institutional life. By including a convenient number of studies, the analysis compares, contrasts and synthesises findings across the studies.

The first step of the metasynthesis was to conduct a targeted search for qualitative studies on secure/residential institutions, inpatient psychiatric care for adolescents and juvenile justice/forensic institutions and select those centring on adolescents' experiences of coercion in everyday institutional life. We used the search words restraint, coercion, restrictive measures, repression in additions to the different sectors, and centred on studies published after 2010. This resulted in 36 studies, which included adolescents' perspective and substantial analysis of their experiences of coercion (see supporting information S1). The aim was not to include all studies, but reach a point of empirical saturation within all three institutional contexts, and include the studies with the most substantial contribution to our understanding of coercion from an adolescent perspective. The second step included careful reading of the qualitative analyses, highlighting all practices and experiences that included experiences and practices of institutional coercion. The guiding question for this step was: How do adolescents experience coercion in their everyday institutional life? The third step included identifying overarching themes that would enable a meta-analysis of the different types of coercion, which adolescents experience. The guiding question for this step was: What types of coercion are adolescents experiencing and what patterns emerge across institutional contexts? The aim of the meta-analysis was to construct a coherent and nuanced bricolage of the multiple forms of coercion that adolescents experience over time in institutional care. The approach allowed for a playful back-and-forth process of inquiry (Kinn et al., 2013).

The method draws on a creative and intuitive approach to analysis of already analysed data, which call for methodological transparency explaining the steps of analysis, and reflexivity regarding the interpretation of the so-called 'thrice removed representations' (Sandelowski 2006 in Kinn et al., 2013, p. 1290). It is a methodological limitation that meta-synthesis results in some level of decontextualising the findings. While we synthesise data from different jurisdictions and different institutional settings, we maintain clarity regarding the original context and research purpose. Our analytical aim was to bring analytical depth and richness to our understanding of coercion in the institutional lives of adolescents. While the form or frequency of coercive practices may differ between sectors and jurisdictions, the metasynthesis of qualitative studies has provided insight patterns and shared experiences.

FINDINGS: EXPLORING COERCION IN THE EVERYDAY INSTITUTIONAL LIVES OF ADOLESCENTS

Our findings are presented in six themes covering a range of restrictions in everyday life that qualify as forms of coercion. The themes are as follows: restrictions imposed by institutional rules; restrictions on contact and communication; restrictions of private space; restrictions on mobility; treatment and rehabilitation as restrictive practice; and physical restraints. We aim to provide nuanced insight into adolescents' experiences of these practices, which highlights coercion as a multilayered and ambiguous practice. The ambiguities stem from a divergence between the multiple reasons and logics that often simultaneously legitimise the use of coercion and

the experience of being coerced. These complexities are vital for understanding coercion in the institutional lives of adolescents and for developing institutional practices to reduce the harmful effects of coercion.

Restrictions imposed by institutional rules

Living in an institutional context implies some degree of deprivation of liberty, due to the institutional rules and organisation that regulate everyday life (Nowak, 2019). The CRC states, in article 12, that children have the right to be heard in matters regarding their everyday life. This includes the right to participate in decision-making regarding where they live, go to school and the organisation of everyday life. While institutional is life often aimed at providing a home-like context of care and allowing some level of collaborative decisions-making, institutional life is regulated by rules and staff directions at many levels (De Valk et al., 2016; Enell et al., 2022; Henriksen et al., 2008). Institutional rules can regulate where and when adolescents can go outside the institution, when and what they can eat, when and where they can sleep, watch TV, etc. There can also be rules about when and how they must do chores, increased control with school attendance and scheduled and/or limited activities within the institutional context.

Adolescents living in institutions often struggle with complex problems such as poor mental health, childhood neglect and trauma, behavioural problems, drug/alcohol abuse and have been assessed as needing structure and staff guidance (Henriksen & Refsgaard, 2020; Ulset & Tjelflaat, 2012; Walker et al., 2005). Rules and staff directions can regulate behaviour such as the use of offensive language, aggressive body posture, yelling, running inside or the display of bad manners. There can be restrictions on clothing and the use of make-up and other forms of expression of self and identity. These behavioural regulations constitute forms of soft power, which shape how adolescents in institutional care can perform their gendered, sexual or ethnic selves (Andersson Vogel, 2018; Henriksen, 2018; Sankofa et al., 2018). The regulatory practices aimed at providing adolescents with social skills and behaviour in accordance with social norms, thus serving purposes of rehabilitation and care, while they can be experienced as micromanagement, punishment and devaluations of who they desire to be.

Institutional care implies being subjected to institutional timing and temporality such as eating, sleeping and performing certain activities at certain times. Staff come and leave at specific times setting an institutional rhythm that shapes when and where activities can take place. The residents become attuned to office hours and are accustomed to waiting; for their case manager to call, for court dates, for inspections, for meetings and for being discharged (Henriksen & Refsgaard, 2021). The uncertainty of release dates or case manager decisions causes a lot of frustration, anger and sadness (Engström et al., 2020). Time passes slowly and at an uneven pace, picking up speed when adolescents are engaged in activities or when daily routines are disrupted, and coming to a halt when they are subjected to time-out or isolation with nothing to do (Bengtsson, 2012; Inderbitzin, 2005).

Lack of control with daily routines can result in boredom and risk-taking to regain some sense of control and agency. In a Danish study, a young boy in secure care states, 'for me, it is shameful being in here. You are being controlled by everyone else' (Henriksen & Refsgaard, 2020 p. 137). Adolescents living in confinement apply strategies for regaining control with small fragments of space and time, such as delayed response to staff directions, being slow at performing tasks or pretending not to hear (Bengtsson, 2012; Cox, 2011). They can also make more explicit trouble such as engaging in quarrels with staff or collective 'bed strikes' to momentarily regain power in

the structured closed setting (Wästerfors, 2011). Bengtsson (2012) refers to such tactics as *'boredom aversion'*, which includes individual and collective risk-taking, which are active responses to feeling a loss of personal control. Inderbitzin (2005) describes the everyday lives of boys in US reform schools for young offenders noting how 'the stifling boredom of their claustrophobic lives' (p. 14) results in illicit behaviour such as smoking, doing drugs, gambling and getting tattoos.

Adolescents living in institutions experience multiple forms of coercion, which range from hard power embedded in sanctions, surveillance and confinement and soft power regulating behaviour and their sense of self through therapy and motivational talks. The experience of institutional rules and regulation is shaped by the way these rules are imposed and adolescents' relations to staff. Studies document the importance of a therapeutic alliance based on trust, empathy and care to be vital for treatment effect (Engstrøm et al., 2020; Harder et al., 2013; Henriksen et al., 2008). A Swedish study from compulsory youth care finds that a 'rule-based interaction style', which includes some degree of punishment, such as violent, rough, impatient and threatening behaviour, contributes to frustration, increased levels of aggression in adolescents and re-traumatisation (Engstrøm et al., 2020). Care-oriented staff are described in the following way by an adolescent, 'They're not so rigid, you know? They're not so severe and things like that – so you can joke with them, we can have fun, we can chat, know what I mean. They can be serious and not so serious' (ibid p. 1032). Studies stress the importance of care, empathy, information sharing, explanation and debriefing in situations involving coercion (Haynes et al., 2011; Hejtmanek, 2016; Hottinen et al., 2012).

Restrictions on contact and communication

According to the CRC, children are entitled to free access to contact and information (articles 13 and 17), and any limitation of these rights must be grounded in the best interest of the child. However, many residential institutions have collective restrictions on access to phone, Internet and visits. Some children may be subject to a care order limiting their contact with one or both parents for a limited period of time often due to physical or psychological abuse. Restrictive measures on communication and contact are often legitimated by logics of care and protection, such as an assessment that the adolescent will benefit from less peer/family influence, less stimuli from social media or because cell phones are used for accessing drugs or planning to abscond (Ulset & Tjelflaat, 2012).

Secure institutions and juvenile justice institutions can have more extensive provision for limiting young people's access to communication and visits, especially for adolescents held in pretrial custody. These institutions often have a ban on cell phones, limited and/or controlled access to online media and visits can be monitored. Residents may be restricted to contacting a list of approved persons and visits require staff approval, to prevent contact with peers involved in crime or assessed to be a bad influence (see Henriksen & Refsgaard, 2020; Walker et al., 2005).

Children and young people express concerns about being disconnected from friends and family, especially when they live in secure units and express views that these restrictions are unjust and punitive (Henriksen & Prieur, 2019). A study from psychiatric inpatient care in the UK paraphrase adolescents describing the closed ward as 'living in an alternative reality' (Haynes et al., 2011). Across diverse institutional contexts and jurisdictions studies report on children feeling alone, afraid and left to themselves in locked institutional care (Ibid, Walker et al., 2005, Schliehe, 2014, Rice et al., 2021). An adolescent in secure care expresses the following, 'The most difficult moments are when you have to go to bed in your room. Really. All thoughts come, you

get anxious, you get stressed, you feel that you have not so fucking many. You feel very powerless. Being able to call someone when you feel bad, you do not have that opportunity' (Nolbeck et al., 2020; p. 9). Multiple factors can shape their experiences of coercion in relation to contact and communication such as being placed far from their home environment, the institution being off-the-grid of public transportation, staff reluctance or denial to assist in finding transport, etc. Limited access to social media may also restrict adolescents' ability to maintain social relations to friends or extended peer groups, which can result in the fear of losing these relations (Haynes et al., 2011; Henriksen & Refsgaard, 2020; Ulset & Tjelflaat, 2012).

Many institutions have restrictions on how the adolescents can engage and interact with each other. This includes house rules that prohibit girls and boys being alone together (to prevent sexual interaction or abuse) or limitations on contact between adolescents living in different units. Sometimes, staff discourage peer interaction to limit negative socialisation (Bengtsson, 2012). In Denmark, it is not unusual to move adolescents from one secure unit to another if staff observe an unhealthy peer group dynamic. This results in frustration and insecurity for the adolescents and a sense of being punished (Bengtsson, 2012; Henriksen & Refsgaard, 2020). A study on adolescents in compulsory psychiatric treatment in the United States reports that peer support during the inpatient treatment was viewed by the adolescents as the most empowering aspect of their treatment (Rice et al., 2021; see also Hejtmanek, 2016).

Restrictions of private space

The CRC emphasises children's right to privacy in article 16, which also applies to children living in state care. Many institutions provide young people with a room of their own, which constitutes their private space inside the public space where staff and other professionals work and have access. There can be restrictions of how these rooms can be personalised, such as how they can be decorated, what private items can be kept inside the room and furniture can be fixed to the wall/floor for safety reasons (Nolbeck et al., 2020; Ulset & Tjelflaat, 2012).

Rooms are only private to an extent; usually doors cannot be locked from the inside and can have peep-holes to enable staff monitoring in case of self-harm or suicidal behaviour (Schliehe, 2014). Limitations can also include not being able to open a window, not being allowed to close a door or control blinds. Furthermore, private rooms are often routinely inspected for drugs or other illicit items such as shavers, medicine or lighters, which staff consider potentially dangerous. Rooms can also be cleared of personal items if the adolescent is assessed as suicidal or self-harming. A young boy in Danish secure care explained, 'I mean, I have nothing private. If they feel like it, they can come in and search the place, search me from top to toe, and in here it's allowed' (Henriksen & Refsgaard, 2020 p. 136). A young woman admitted to psychiatric care stated, 'It feels like I left my dignity at the door' (Schliehe, 2014, p. 80) as a comment to being exposed to staff watching her go to the toilet and shower. Adolescents can also be asked to provide urine samples for drug testing, pregnancy/venereal disease testing or be subjected to body search upon re-entry or after a visit. While these measures are applied to safeguard the adolescents, they experience a loss of control, disrespect of personal boundaries and ultimately their sense of self (Henriksen, 2017; Inderbitzin, 2005; Nolbeck et al., 2020; Ulset & Tjelflaat, 2012). It can result in trouble sleeping, nightmares, anxiety and general unrest (Schliehe, 2014; Henriksen, 2017).

Children and young people in institutional care are often subject to some form of diagnostic surveillance. Sometimes, the main objective of their stay is to make a psychiatric or sociopsychological assessment to enable care or treatment in the right institutional context (Enell, 2017).

This implies being observed and assessed in everyday activities and interactions with staff and peers and having these entered into electronic logs accessible to the staff (Cox, 2011; Walker et al., 2005). By implication, the adolescents have limited control over their personal information, which is often passed between professionals without the knowledge or explicit consent of the child. As expressed by an adolescent, 'I want to know beforehand what they put into the computer and what I can just tell normally, without immediately telleing the whole [name of institution] and that the staff can read it' (De Valk et al., 2019; p. 771). Diagnostic surveillance constitutes a form of soft power on the coercion continuum, because as the adolescents become conscious of what enters their logs their conduct is self-regulated. As a young boy in secure care explained, 'I think about what they write, if I speak out it can cost me a month in here. You have to think about that' (Henriksen & Refsgaard, 2020 p. 141). Diagnostic surveillance is ambivalent in that it enables assessment and protection in the care setting, while it can be experienced as a violation of privacy and behaviour is regulated from fear of what staff will write about them.

Restrictions of mobility

Freedom of mobility is a fundamental human right, and according to the CRC article 37, confinement can only be used as a last resort and for the shortest length of time. Adolescents living in institutions can experience restrictions on their mobility by rules regulating where and when they can go outside the institution, access to kitchen or recreational areas only by staff permission, restrictions on entering other residents' private room, etc. As explained by an adolescent in a secure institution, 'You can't just leave when you want to, the fridge is locked, you can't make a call when you want to, everything, I mean everything has to be discussed even whether you want to go upstairs, or get a cup of water or something' (De Valk et al., 2019, p. 679). Most Western countries, excluding Norway and Finland, have secure institutions for children assessed to be a danger to themselves or others, and for surrogate remand. A study from the Netherlands developed a definition of seclusion to be 'an involuntary placement in a room or area the client is not able or allowed to leave' (van Dorp et al., 2021). This definition opens our understanding of seclusion or confinement as more than a locked door. Single-person placements are used in for example Denmark and Norway, where a single child lives with staff with none or limited peer contact. In Norway, these placements have been critiqued for being de-facto isolation, where children's mobility is restricted by remote placement rather than locked doors (Havre, 2018).

Many institutions apply practices of time-out, where an adolescent is excluded from unit activities for a few hours or several days, as a consequence of bad behaviour or breach of rules (see Enell et al., 2022; Ulset & Tjelflaat, 2012). Time-out can be used to enable the adolescent to regain emotional or behavioural control, to protect the adolescent from a situation escalating into physical restraint or as punishment for breaking rules. A time-out can be in the young person's room or a separate part of the building, which is de facto a form of isolation. Seclusion or time-out can be experienced as random and readily used by staff to regulate minor rule-breaking, as this quote illustrates, 'You know, in order to put a youth in individual care, a lot of paper is required. But for seclusion, nothing is required' (Nolbeck et al., 2020, p. 9). This illustrates how confinement can be experienced in fractions (Kalliomaa-Puha et al., 2021), implying that adolescents can be placed in time-out or isolation within a locked institution. Some institutions have a low-stimuli room, which is used for distressed persons who are considered a risk to themselves or others. These rooms are often small, with white walls and basic furniture (often just a bed) bolted to the floor. Schliehe (2014) describes the so-called back-cells in the Scottish penal system, as

rooms stripped of inventory with no natural light used for punishment or for patients with severe mental illness. The rooms are usually used for shorter periods of time such as for a few hours with staff monitoring. For the adolescent, it can be a scary and undignified experience, which feels more like punishment than care or protection (Ibid., Henriksen, 2017).

Secure or juvenile justice institutions can look very different across jurisdictions and sectors, some with a distinct penal materiality making them resemble youth prisons. Fences, concrete walls, surveillance cameras, barbwire, locked doors and bars in front of the windows are examples of a penal materiality (Foucault, 1976/2003). Sometimes, staff carry uniforms, alarms and have keys dangling at their belt, and furniture can be scarce or bolted to the surfaces. Nolbeck et al. (2020) argue that these materialities produce distinct sociomaterial control practices that communicate to adolescents that they are viewed as dangerous, unreliable and not worthy of care and respect. Adolescents are often shocked at arrival in secure institutions, expressed in sentiments such as, 'what is this place? It looks like a prison' (Henriksen & Refsgaard, 2020 p. 126) or 'Like the way you basically get strip searched when you come in here. Or like... the way you have to give them all your stuff and put on these outfits. It feels like I'm in jail here' (Rice et al., 2021, p. 6). After some time inside a locked institution, many adolescents adapt to the institutional context and confinement is normalised (Ulset & Tjelflaat, 2012). They also develop strategies for obscuring the penal materiality such as closing blinds to avoid seeing the fence outside (De Valk et al., 2019). In hindsight, many of the adolescents acknowledge their need for placement and some appreciate the structured everyday life (Haynes et al., 2011; Steckley & Kendrick, 2008; Walker et al., 2005), but the first couple of weeks can be dominated by emotions such as fear, uncertainty, frustration and longing for family and peers (Enell, 2017; Henriksen & Refsgaard, 2020). Schliehe (2014) argues that the emotional response of young women having lived in secure care can be nightmares, anxiety and anger, which endure long after the stay has been terminated.

Treatment and rehabilitation as restrictive practice

Treatment in institutional care can imply a range of practices on the coercion continuum. Coercion as soft power includes practices such as motivational talks, therapy and cognitive treatment programmes, which are aimed at regulating behaviour or thinking (Cox, 2011; Nolbeck et al., 2020). Treatment can also include coercion as hard power when adolescents are subjected to forced feeding or medicalisation, restraints or seclusion.

The use of cognitive programmes and motivational talks is widely used in child welfare and juvenile justice institutions, such as anger management training, victim awareness training and moral reasoning programmes aimed at correcting adolescents' 'thinking errors' or neutralisations (Cox, 2011; Sankofa et al., 2018). Many institutions apply some form of reward system based on earning points and passing through levels to obtain financial gains and other privileges (see Tompkins-Rosenblatt & VanderVen, 2005). Cox argues that adolescents engage in 'the adoption of an institutional persona of a changed self' (2011, p. 602), where they comply with programme aims of taking responsibility for changing their life, while they preserve an authentic self. A Swedish study from secure care also finds that adolescents present an altered self to obtain privileges and a hope for early release (Nolbeck et al., 2020; see also Cox, 2011). Studies document how adolescents resist the technologies of soft power by refusing to confide in or talk to staff, as expressed by a young man in a Danish secure institution, 'they can force me to be here, but they can't force me to change' (Henriksen, 2018, p. 436). The young man kept the staff at a

distance refusing to confide in them or engage in reflection and self-assessment, which resulted in staff considering him a potential risk in need of more intensive observation and control (ibid).

Studies document that a substantial number of children and young people in child welfare institutions and juvenile justice have significant mental illness and psychiatric diagnoses (Henriksen, 2017; McElvaney & Tatlow-Golden, 2016). They live in institutions that often lack the specialised knowledge to provide adequate care for them and some oscillate between (acute) inpatient psychiatric treatment, juvenile justice and child welfare institutions. In Danish secure institutions, staff express concern about these adolescents, admitting that 'we can protect them, but we cannot provide them with the treatment they need' (Henriksen, 2017 p. 685). Protection can include a range of coercive measures such as 24-h observation, body and room searches, isolation and separation from peers, which the young people largely experience as punitive or degrading. Studies highlight the use of euphemistic language, framing punishment or control practices as treatment, which an adolescent also expresses, 'Just punishment. That's it. But they try to hide it. Treatment. Treatment this and that. This isn't treatment, it's just punishment' (De Valk et al., 2019, p. 772). Feelings of shame, stigma and unworthiness due to mental illness can be deepened by experiences of coercion. Being granted freedom, such as being allowed out for a few hours or a home visit, can indicate trust and reliability, which builds young people's self-esteem (Haynes et al., 2011).

In psychiatric wards, young people can experience treatment as involuntary for numerous reasons, the most common being that parents gave consent to their treatment and/or they did not participate in the process of making their treatment plan (Coyne et al., 2015; Tan et al., 2010). Adolescents in psychiatric care can be subjected to involuntary medicalisation such as sedatives or forced feeding, and staff can use seclusion or time-out as an element of treatment (Hottinen et al., 2012). For adolescents with eating orders, involuntary treatment can take place on a daily basis, often coupled with restrictions on their mobility and surveillance (Tan et al., 2010).

Only a limited number of studies document adolescents' experience of inpatient psychiatric care. These studies suggest that treatment constitutes an ambiguous exercise of care, treatment and control (Hottinen et al., 2012; Tan et al., 2010). Based on adolescents' own reports on coercion in relation to eating disorders, coercion is viewed acceptable in order to save lives, but not acceptable as an element of treatment (Tan et al., 2010). Nyttingnes (2018) studied the level of experienced coercion in Norwegian adolescent inpatient care, finding that if adolescents perceived restrictions as legitimate, the patients experienced low degree of coercion. On the contrary, if restrictions were experienced to violate their freedom rights, their experience of coercion increased and the adolescent often felt humiliated. Studies suggest that the experience of coercion relies on multiple factors such as the legitimacy, urgency and the patient–staff relationship (Engström et al., 2020; Jones et al., 2021; Rice et al., 2021).

PHYSICAL RESTRAINTS

The use of physical restraints (holding or physical guidance) is widely used particularly in locked institutional settings. Some studies report on the detrimental effects of using physical restraints in the treatment of children and adolescents (Nielson et al., 2021; Nowak, 2019), while others provide a more nuanced understanding of restraints as a complex and multifacetted experience for both staff and adolescents (Rice et al., 2021; Slaatto et al., 2021; Steckley & Kendrick, 2008; Tan et al., 2010). These studies emphasise that restraints can be experienced as care and protection if they take place within a relationship defined by trust and mutual respect. An adolescent

explains, 'It's not like trying to hurt you or that, they're trying to keep you safe' (Steckley & Kendrick, 2008, p. 563). The purpose of using restraints is always to protect the child or young person from harming themselves or others. However, children can experience restraints as punitive, unduly harsh or unwarranted (Hottinen et al., 2012; Steckley & Kendrick, 2008; Ulset & Tjelflaat, 2012) and staff in juvenile justice report sometimes using restraints as punishment for violating rules or staff orders (Cox, 2011). Particularly, in residential institutions, children report experiencing the use of restraints as a means for staff to assert power (De Valk et al., 2016; Ulset & Tjelflaat, 2012), and studies report how group workers and young people can be caught in a coercion '*trap*' (De Valk et al., 2016, p. 209), where their reactions towards each other escalate in order to achieve dominance. Studies document that adolescents are also emotionally affected by witnessing others being restrained (Cox, 2011). Vishnivetsky et al. (2013) found that adolescents subjected to coercive care experience seclusion less frightening than restraints. However, more research is needed of adolescents' experiences of physical restraint (Slaatto et al., 2021).

DISCUSSION

Coercive measures in institutional settings for adolescents are used for different purposes to solve an acute or long-lasting mental or/and behavioural problem, often triggered by self-harm (Douzenis & Michopoulos, 2015), aggression or forms of non-compliance (Coutant, 2016; Hejtmanek, 2016). Some forms of coercion such as seclusion, forced medicalisation/ feeding and physical restraints are regulated by legislation, require care orders, parental consent and enter formal registrations of coercion. Other forms of coercion are embedded within institutional practices and organisational logics, such as house rules and pedagogic practice that regulates behaviour and everyday dispositions. The analysis shows that adolescents experience multiple forms of coercion in their everyday institutional life ranging from hard forms of power with no or little possibilities to escape the situation (Nyttingnes, 2018; Pelto-Piri et al., 2016) to soft forms of power regulating adolescents' conduct and self (Foucault, 1976/2003). While these restrictions are set in place for their protection and/or treatment, adolescents experience many of these coercive practices as punitive, resulting in loneliness, anxiety, fear and feeling unworthy (Rice et al., 2021; Schliehe, 2014; Ulset & Tjelflaat, 2012) and reduced trust in staff (Furre et al., 2016; Pelto-Piri et al., 2016). However, coercion can also confirm their sense of being cared for and protected against themselves or a chaotic everyday life at home or on the street (Steckley & Kendrick, 2008).

The metasynthesis suggests that coercion is a multilayered and ambiguous experience in the institutional everyday lives of adolescents. We argue that coercion must be understood as a continuum of hard and soft power, which illuminates the range of control practices that permeate their everyday lives. By placing these forms of coercion in a continuum rather than as distinct forms of power, we highlight how hard and soft power operate in extension of each other. The blurred distinction between hard and soft power results in ambiguities, for example when coercion is exercised to provide treatment or care but is experienced as punitive (such as restraints or forced feeding/medicalisation), or when coercion is exercised as protection with elements of punishment (such as time-out, body search or seclusion). The coercion continuum also highlights the magnitude of coercion in adolescents' institutional everyday life. Restrictions on their mobility, their privacy, their communication and contact serve as a backdrop of experiences of restraints, seclusion and forced treatment, and these experiences of coercion accumulate over time and across institutional contexts.

Coercion can be vital for the protection or treatment of adolescents, but it is also important to respect their right to autonomy and participation in matters concerning their everyday life (Lefevre et al., 2019). The CRC grants children rights of mobility, contact and communication and privacy, which are often undermined by concerns about children's safety or best interest. The analysis shows how coercion routinely undermines these rights often based on collective rules and logics of care/punishment, which can be detrimental for adolescents' development and for learning the skills needed for autonomous decision-making and self-reliance (Hottinen et al., 2012). While coercion can be vital for survival, developing a strong sense of self-efficacy and skills for self-reliance, decision-making and participation is vital for successful transition to adulthood. As argued by Cox (2011), 'These facilities may serve to deepen the patterns of marginality that these young people have experienced' (Cox, 2011, p. 605). Advancing participatory methods to organise everyday life and include adolescents in their care/treatment plans remains important for self-efficacy and effective treatment (Bjønness et al., 2020; Kaltiala-Heino & Eronen, 2015; Michaud, 2017).

CONCLUSION

This metasynthesis highlights coercion as an ambivalent and multilayered experience that permeates the everyday institutional lives of adolescents. While hard forms of coercion such as seclusion, restraints and forced treatment are often highlighted as harmful for adolescents, we argue that we need to view these practices in a more nuanced perspective, which includes the perspective of adolescents and a more refined understanding of their forms of resistance. We also argue that coercion as soft power permeates the everyday lives of adolescents in state care, which needs to be acknowledged to increase the effect of treatment and improve the well-being of these adolescents. Further research is needed to understand the impact of coercion in the lives of adolescents in state care, including ethnographic studies of closed institutional space and longitudinal studies following adolescents over time and across institutional contexts.

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CONFLICT OF INTEREST STATEMENT
There are no conflicts of interest.

DATA AVAILABILITY STATEMENT
The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL
The article does not draw on empirical data and ethical approvals are not relevant.

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ENDNOTE

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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